January 2010

Dear Patient:

New Federal Guidelines require all Surgery Centers to comply with new Medicare Conditions of Coverage, effective on May 18th, 2009. The new conditions for coverage require **ALL** patients (not just Medicare patients) to receive specific written and verbal information in advance of your surgery related to patient's rights and responsibilities, disclosure of physician ownership in the center, information and facility policies concerning advanced directives, and information concerning the patient's informed consent.

I have sent copies of Parham Surgery Center's paperwork with this cover letter to ask you to complete and return them either by mail or fax at (804) 591-2236 at your earliest convenience. Federal Regulations require the Surgery Center to have this written communication on file at least 24 hours prior to your procedure, and failing to do so will require your procedure to be cancelled and rescheduled to another time until we are able to complete this requirement. There are 4 papers on the left side of the folder you will need to submit: Patient Registration, History Screening form, Medication Reconciliation, and the Patient's Rights form must be signed and dated at the bottom.

At least 24-48 hours prior to your procedure, a Surgery Center staff member will verbally review your rights and responsibilities, pre-operative instructions, contact you regarding any insurance issues and/or financial obligations, and answer any questions you may have concerning your procedure. If the Surgery Center has not successfully reached you at least 24 hours prior to your procedure, please call Parham Surgery Center between 08:00 and 4:30 PM Monday-Friday at (804) 591-2226.

Parham Surgery Center's team of staff and physicians is dedicated to providing quality, personalized healthcare to the members of our community. We look forward to serving you.

If you have questions concerning any of these requirements, please contact the PACU at 804 591-2226.

Sincerely,
Peggy Ellis Turner, RN Nurse Manager Parham Surgery Center
Ph: (804) 285-4763 and ask to have me paged/Direct 804 591-2204
FAX: (804) 288-8946 or 804 591-2236

Parham Surgery Center

HCA Virginia Health System

An HCA affiliate

7640 E Parham Road
Henrico, VA 23294
www.parhamsurgerycenter.com
804-591-2200

Online Pre-Surgical History Instructions

Welcome to Parham Surgery Center. We're very pleased that you and your physician have chosen us to care for you.

To start the pre-surgical assessment process, Parham Surgery Center requests that you fill out your medical history online with *One Medical Passport*.

We recommend that you enter your medical history online as soon as your surgery has been scheduled. Once you do this, our Pre-Surgical Assessment nurse will be able to access the information you entered online. This information will assist the nurse in organizing and documenting your complete medical history to prepare for your surgery.

To begin your online Pre-Surgical Assessment,
1) Go to our website: http://www.parhamsurgerycenter.com/
2) Select "Fill Out Your Online Medical History" on the front page.
3) Click "**One Medical Passport**"
4) Accept the terms of use and click "**Register**"
5) Complete the registration and medical history screens, click Finish to submit your Medical Passport to the medical facility

Be sure to have the following information available before starting your *Medical Passport*:

- Your health insurance information.
- The names, addresses and phone numbers of your physicians.
- A list of all medications you are taking, their dosage and frequency.
- A list of surgical procedures you have ever had and their approximate dates.

Note: If you are not able to complete your history online, please call our Preop nurse between 8:00 and 4:00 at (804) 591-2200 as soon as possible to complete your health history. You will still need to have the above information available when you call. Please allow 20-30 minutes for this call.

About *One Medical Passport*

Completing a *One Medical Passport* medical history online is easy. For most patients, filling out the entire questionnaire takes less than 30 minutes. Please fill out the questionnaire accurately, and be assured that all of your information is kept confidential and will be thoroughly reviewed by your medical team. At any time, you can quit filling out the questionnaire and come back and complete the unfinished portion at a more convenient time.

One Medical Passport is a website that allows you to enter your information at any time from anywhere. You can also print out a copy of your medical history after you create it online and keep it with you or with your other health care documents, as well as have access to it online anytime you need it or want to update it

PARHAM SURGERY CENTER
MEDICATION RECONCILIATION LIST

Print Name: _____ **Allergies:** _____

_____

The following is a list of medications as provided by you when you arrived today.

	Medication	Dosage	How Often	Take for what purpose
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Information Below Completed DAY OF SURGERY

Your doctor has prescribed a new medication for you today.

	Medication	Dosage	How Often	Take for what Purpose
1.				
2.				
3.				
4.				

☐ **No Prescription; *OR***

Prescription Given: ☐In office ☐To family ☐To Pt @ discharge

Medication Instructions:

☐ Continue pre-operative medications as ordered by prescribing physician(s). Consult prescribing physician for any questions or concerns.

☐ Stop the following medication _____ and call prescribing physician within the next 24 hours to determine when to re-start medication.

☐ If your physician instructed you to stop taking any medication prior to your procedure today, please call the prescribing physician for further instructions.

Patient/**Responsible Party**:_____ Date: _____Nurse:_____

Additional information: _____

_____

YOU MAY TAKE THIS WITH YOU TO ALL MEDICAL APPOINTMENTS

If you have any questions regarding your medications, please call your physician's office.

This is being provided to you as part of the **National Patient Safety Initiative** to reduce medical errors and improve patient safety.

PARHAM SURGERY CENTER
Patient's Rights and Responsibilities
PH (804) 285-4763 Fax (804) 288-8946

Parham Surgery Center's team of staff and physicians is dedicated to providing quality, personalized healthcare to the members of our community.
Our plan of care encompasses all aspects of your surgical experience. Your pre-operative intra-operative and optimal recovery needs will be met to the best of our best ability while you visit our center.

At the Parham Surgery Center your rights include the following:

- Safe considerate and respectful care
- Privacy, personal and informational
- Be kept well-informed and participate in your healthcare decisions
- Know the names and roles of Care-givers
- Be fully informed of risks, benefits, expected outcomes and alternative treatments for scheduled procedures
- Consent to or refuse treatment without being subjected to discrimination or reprisal
- An advance directive, such as a living will, health care proxy, or surrogate decision maker
- Confidentiality of your medical record
- Review your medical record
- Awareness of the potential ownership interest in the facility by your physician
- Consultation with a specialist
- Participate in your pain management treatment to enhance your recovery
- Consent to or decline to take part in research affecting your care
- Know about center rules that will affect you, your treatment and your payments
- Access protective services
- Access to an interpreter
- Accommodation of special needs for handicapped or sensory impaired persons
- Explanation of the need for your transfer to another facility

We do not honor a "Do Not Resuscitate" advanced directive.
To voice concerns or grievances regarding care received please contact:
PSC Administrator/Nurse Manager @ 804-285-4763
Virginia Department of Health (804) 367-2104 or Toll-Free at 1 (800) 955-1819
Medicare Beneficiary Ombudsman at www.cms.hhs.gov/center/ombudsman.asp
Or 1 (800) Medicare

You have the responsibility to:

- Provide information about your present and past health history and medications
- Ask questions when you do not understand information or instructions
- Keep your health care providers informed of your level of discomfort in a timely manner to maximize the effectiveness of your pain management treatment plan
- Be considerate of the rights of other patients, center staff and center rules and regulations
- Inform us if you have an advance directive and provide a copy to the center
- Comply with the treatment plan and instructions for follow-up care
- Assure financial obligations for healthcare services received are promptly met
- Inform center personnel if any special needs or accommodations are required

DISCLOSURE OF OWNERSHIP

☐ **Physician does** have a financial interest in this facility. ☐ **Physician does not** have a financial interest in this facility.

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE RECEIVED THIS INFORMATION, READ AND UNDERSTAND ITS CONTENTS AND IT HAS BEEN REVIEWED VERBALLY PRIOR TO THE DATE OF SURGERY.

Signature:_____ Date received and reviewed:_____
Printed Name_____ Date of Birth_____ Date of Surgery_____

Parham Surgery Center

HISTORY SCREENING FORM

7640 E Parham Road Henrico, VA 23294 PH (804) 285-4763 FAX (804) 288-8946

NAME_____ AGE_____ DOB_____ SS_____

SURGEON_____ Family Doctor &Phone #_____

SURGICAL PROCEDURE_____ Date of Surgery_____

Height_____ Weight_____ Last Menstrual Period _____ Phone Numbers: H:_____ Cell:_____ Work_____

EMERGENCY CONTACT NAME & NUMBER_____

HISTORY OF	YES	NO	COMMENTS	HISTORY OF CONT.	YES	NO	COMMENTS
Arthritis or Gout				**Heart Disease / Problems**			
Bleeding tendencies				• Angina / Chest Pain			
Clotting tendencies (incl: DVT)				• Heart attack			
Cancer, Growths, Tumors				• Stents			
Diabetes: type I; type II				• Pacemaker			
High Blood Pressure				• Defibrillator			
Lung/Breathing Disorders				• Heart Murmur			
• Asthma				• Mitral Valve Prolapse			
• Bronchitis				***OTHER:***			
• COPD				Metal Implants or Artificial Joints			
• Sleep Apnea				Cough longer than 3 weeks			
• Use CPAP				Night Sweats			
Gastrointestinal Problems				Eye Disease			
• Reflux				Unexplained weight loss			
• Hiatal Hernia				Catheters			
Kidney Disease				Dentures			
Neurological Disorders				Hearing Aid			
Stroke or Seizure				Contacts/glasses			
Liver Disease or Hepatitis							
Endocrine Disorders (thyroid)				***ALLERGIES***			
Sexually Transmitted Disease				Drug			
HIV Positive				Food Allergies			
Depression				Environmental Allergies			
Psychiatric Treatment				Latex:			
HABITS				Other			
Alcohol Use							
Tobacco Use							
Recreational Drug Use							
Other Conditions not addressed:							

Medications: Please complete separate Medication Reconciliation Form

If you have answered *YES* to anything above, **PLEASE Explain:**_____

Previous Hospitalizations and/or surgeries: _____

Previous Anesthesia? ☐**YES** ☐**NO** **DATE OF LAST:** _____ **WHERE?** _____

Have you or a relative had a problem with anesthesia OR a history of UNEXPLAINED High Fever after surgery? YES☐ ☐NO *IF YES, SPECIFY:*

*****PLEASE MAIL OR FAX COMPLETED FORM TO THE SURGERY CENTER IMMEDIATELY*****

QUESTIONS? CALL PACU at (804) 591-2226

PARHAM SURGERY CENTER

Patient Data & Insurance Information Sheet
Please Print – Bring Insurance Cards – Photo ID

Procedure Date _____/____/_____ **Surgeon Name** _____

Patients Information

Patient Name _____ _____
Last **First** **Middle** **Race**

Social Security # _____-_____-_____ **Date of Birth** _____/_____/_____ **Sex: Male Female**

Address _____ **City** _____ **State** _____ **Zip Code** _____

Home Phone: (____) ____-_____ **Work Phone:** (___) ___-_____ **Cell or Pager Number:** (___) _____-_____

Employer Name/Address/Phone: _____ _____
Occupation

Emergency Contact: _____ **Contact Phone Number:** (___) ___-_____

Emergency Contact Relationship to patient: _____

Responsible Party Information

Responsible Party Name: _____ **Relationship to patient: Self Spouse Parent Other**

Social Security # _____-_____--_____ **Date of Birth** _____/_____/_____ **Sex: Male Female**

Address _____ **City** _____ **State** _____ **Zip Code** _____

Home Phone: (____) ____-_____ **Work Phone:** (___) ___-_____ **Cell or Pager Number:** (___)_____-_____

Employer Name & Address _____

Accident Information

Accident Type: None W/C Auto Other Accident/Injury Date _____/_____/_____

Insurance Information

***Primary Insurance*:** _____ **Phone Number:** (___) ___-_____

ID #/Claim # _____ **Group #**_____ **Group Name**_____

Planholder Name: _____ **SSN:** _____ **DOB:** _____

***Secondary Insurance*:** _____ **Phone Number:** (___) ___-_____

ID #/Claim # _____ **Group #**_____ **Group Name**_____

Planholder Name: _____ **SSN:** _____ **DOB:** _____

***Tertiary Insurance*:** _____ **Phone Number:** (___) ___-_____

ID #/Claim # _____ **Group #**_____ **Group Name**_____

Planholder Name: _____ **SSN:** _____ **DOB:** _____